OFFICE OF THE CORONER

Adams & Broomfield Counties

Monica Broncucia-Jordan

CHIEF CORONER

Name: SAMIMI, Kamyar
Case Number: A17-3073
Date of birth: January 3, 1953
Age: 64 years
Date and time pronounced deceased: December 2, 2017; 1202 Hours
Death Investigator: Brooke Steven
Prosector: Steve Cina
Autopsy Technician: Wendy Simpson

OPINION

The cause and manner of death opinion is based on the scene investigation, examination findings, and history available at this time.

Cause of Death: Undetermined

Contributing Factors: Chronic Obstructive Pulmonary Disease (Emphysema) and Gastrointestinal Bleeding

Manner of Death: Undetermined

02/05/2018

Monica Broncucia-Jordan, Chief Coroner

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AUTOPSY REPORT

NAME: KAMYAR SAMIMI **ME#:** A17-03073

DATE AND TIME PRONOUNCED DEAD: December 2, 2017 / 1202 Hours

DATE AND TIME OF AUTOPSY: December 6, 2017 / 1000 Hours

AGE: 64 **RACE:** White **GENDER:** Male

CIRCUMSTANCES OF DEATH

This 64-year-old male was transported emergently to University of Colorado Hospital on December 2, 2017. He was reportedly in the custody of ICE officers at the immigration detention center in Aurora at the time of his medical incident. He had been in the facility for two weeks prior to the incident and was under a direct supervision suicide watch when he was observed to be "spitting up blood". Apparently he had been suffering from gastrointestinal bleeding in the past. His social history included opium addiction at the age of six and addiction to methadone since 1990. He had been "clean" for two weeks in the ICE facility and was being watched for withdrawal, dehydration, nausea and vomiting.

IDENTIFICATION

The decedent was identified by ICE officers. This was confirmed by fingerprints.

CIRCUMSTANCES OF POSTMORTEM EXAMINATION

The autopsy was authorized by the Coroner of Adams County, Colorado. Prosecting was Dr. Stephen J. Cina and assisting were autopsy technicians Simpson, Morales and Hermosillo. The autopsy was performed at the Adams County Coroner's Office.

CLOTHING AND PERSONAL EFFECTS

The decedent was clad in white socks and cutaway white boxer shorts.

EXTERNAL EXAMINATION

The body was that of a thin, White male. An appropriate identification tag was on the left great toe and hospital identification tags were on the left ankle and left great toe. The body weighed 141 pounds, was 68 1/2-inches in height and appeared compatible with the reported age of 64 years.

The body was cool. Full rigor mortis was present to an equal degree in all extremities. Mild, fixed, purple lividity was distributed over the posterior surfaces of the body, except in areas exposed to pressure.

The scalp hair was receding, black with gray and 2 1/2-inches in length. Facial hair consisted of a black with gray beard and mustache. The irides were brown, the corneae were clear, the sclerae were white, and the conjunctivae were pink/tan and free of petechiae. Bloody black fluid flowed from the mouth and nose. The earlobes were not pierced. There were moderate transverse creases of the lower pinnae. The nasal skeleton was palpably intact. The lips were without evidence of injury. The lower teeth were in poor condition and the upper jaw was edentulous.

Examination of the neck revealed no evidence of injury. Perimortem injuries to the chest will be described below. The abdomen was flat and there was a possible 1-inch scar at the right anterior costal margin.

The extremities showed no gross bony deformities or pitting edema. There was a 3/4-inch scar on the right second finger and a 3/16-inch scabbed abrasion at the tip of the left second finger. The fingernails were intact. Tattoos were not noted. Needle tracks were not observed.

The external genitalia were those of a circumcised adult male. The posterior torso was essentially without note. The anus was atraumatic.

EVIDENCE OF THERAPY

Evidence of medical intervention consisted of bilateral tibial intraosseous lines; an endotracheal tube; two defibrillator pads on the chest; intravenous catheters in the right antecubital

fossa and dorsal left hand; and venipuncture sites covered by dressings on the left forearm and in the left antecubital fossa.

EVIDENCE OF INJURY

A 1/4-inch abrasion was on the right side of the bridge of the nose. A 5/8-inch abrasion was on the lateral right zygomatic region.

There were vaguely rectangular yellow abrasions overlying the sternum. Right ribs 3 - 7 and left ribs 2 - 6 were fractured anterolaterally. There was minimal associated internal bleeding.

INTERNAL EXAMINATION

Body Cavities:

The body was opened by the usual thoracoabdominal incision and the chest plate was removed. No adhesions or abnormal collections of fluid were present in any of the body cavities. All body organs were present in the normal anatomical positions. The subcutaneous fat layer of the abdominal wall was 1.2 cm thick.

Head: (Central Nervous System)

The scalp was reflected. The calvarium of the skull was removed. The dura mater and falx cerebri were intact. There was no subdural or epidural hemorrhage. The leptomeninges were thin and delicate. The cerebral hemispheres were symmetrical. The structures at the base of the brain, including the cranial nerves and blood vessels, were intact. Coronal sections through the cerebral hemispheres revealed no focal lesions. Transverse sections through the brainstem and cerebellum were unremarkable. The brain weighed 1,450 grams. The spinal cord was not examined.

Neck:

Examination of the soft tissues of the neck, including the strap muscles and large vessels, revealed no abnormalities. The hyoid bone and larynx were intact.

Cardiovascular System:

The pericardial surfaces were smooth, glistening, and unremarkable; the pericardial sac was free of significant fluid or adhesions. The coronary arteries arose normally, followed the usual distribution, and were widely patent with no evidence of significant atherosclerosis or thrombosis. The cardiac valves were unremarkable. The chambers and valves exhibited the usual size-position relationships.

The myocardium was red/brown and firm with no focal lesions; the atrial and ventricular septa were intact. The aorta and its major branches arose normally, followed the usual course, and were widely patent. The vena cavae and their major tributaries were returned to the heart in the usual distribution and were free of thrombi. The heart weighed 300 grams.

Respiratory System:

The upper airway was clear of debris and foreign material; the mucosal surfaces were smooth, yellow/tan and unremarkable. The pleural surfaces were smooth and glistening with no focal lesions. The pulmonary parenchyma was purple/tan with diffuse emphysematous changes and bullae at the apices. The parenchyma exuded a mild amount of foamy fluid upon sectioning. There was marked anthracosis. No mass lesions were noted. The pulmonary arteries were normally developed, patent, and without thrombus or embolus. The right lung weighed 480 grams; the left lung weighed 450 grams.

Liver and Biliary System:

The hepatic capsule was smooth, glistening and intact covering uniformly brown parenchyma. No mass lesions were noted. The gallbladder contained 4 mL of viscous, green/brown bile; the mucosa was velvety and unremarkable. The extrahepatic biliary tree was patent, without evidence of calculi. The liver weighed 1,500 grams.

Alimentary System:

The tongue exhibited no evidence of recent injury. The esophagus was lined by gray/white, smooth mucosa. The gastric mucosa was slightly autolyzed and the lumen contained 10 mL of bloody fluid. The small and large bowels were unremarkable.

The ilium contained approximately 100 mL of partially digested blood and firm, black stool resided within the colon. No specific site of bleeding could be identified. The pancreas had a normal gray/white, lobulated appearance and the ducts were clear. The appendix was present.

Genitourinary System:

The renal capsules were smooth and thin, semitransparent, and stripped with ease from the underlying smooth, red/brown cortical surfaces. The cortices were sharply delineated from the medullary pyramids which were purple/tan and unremarkable. The calyces, pelves, and ureters were without note. The urinary bladder was empty; the mucosa was gray/tan and wrinkled. The right kidney weighed 110 grams; the left kidney weighed 130 grams. The prostate gland was unremarkable.

Reticuloendothelial System:

The spleen had a smooth, intact capsule covering red/purple, moderately firm parenchyma; the lymphoid follicles were unremarkable. The regional lymph nodes appeared normal. The spleen weighed 120 grams.

Endocrine System:

The thyroid and adrenal glands were unremarkable.

Musculoskeletal System:

Muscle development was normal. There was moderate degenerative joint disease of the thoracolumbar vertebral column. No nontraumatic bone or joint abnormalities were noted.

SPECIMENS/EVIDENCE OBTAINED

Samples of peripheral blood, heart blood, cavity blood, gastric contents, and vitreous fluid were obtained for toxicology.

A DNA card was retained for the file.

Samples of the major organs were submitted for stock in formalin.

Two cassettes were submitted for histologic analysis.

MICROSCOPIC DESCRIPTION

A - Left lung: disrupted septae; atelectasis; anthracosis; edema; bacteria without inflammation; interstitial chronic inflammation

Liver: moderate steatosis

Left ventricle: unremarkable

B - Right lung: disrupted septae; atelectasis; anthracosis; edema; bacteria and intrabronchial gastric contents without inflammation; interstitial chronic inflammation

PATHOLOGIC DIAGNOSES

I. Chronic obstructive pulmonary disease (emphysema) with marked anthracosis and terminal aspiration

II. Lower gastrointestinal hemorrhage

III. Thoracolumbar degenerative joint disease

IV. CPR-related injuries

V. Minor abrasions of face

VI. Moderate hepatic steatosis

VII. Toxicology (NMS Labs 17380380, peripheral blood): Negative

VIII. Vitreous humor, chemistry studies:
- A. elevated glucose (183 mg/dL)
- B. Mild renal dysfunction
  1. Urea nitrogen = mg/dL
  2. Creatinine = 1.9 mg/dL
- C. No evidence of dehydration

OPINION

This 64-year-old, White male, Kamyar Samimi, died of undetermined causes. Chronic obstructive pulmonary disease (emphysema) and gastrointestinal bleeding likely contributed to death. Methadone withdrawal cannot be ruled out as the cause of death, however, deaths due to methadone withdrawal are rare. There were no injuries to explain death nor was there evidence of dehydration.

STEPHEN J. CINA, MD, FCAP, D-ABMDI
Forensic Pathology Consultant

January 30, 2018

Date

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